MIPS: The 'death knell' for small practices?

Robert A. Berenson, MD, of the Urban Institute says CMS' value-based performance measures are 'PQRS on steroids'

by **JOSEPH BURNS** *Contributing author*

HIGHLIGHTS

- With MIPS, Congress is combining PQRS, Meaningful Use and the value-based modifier.
- One concern about judging physicians based on outcomes, Berenson says, is we have better and more valid measures for organizations than we do for measuring individual physician performance.

Beginning in 2019, the new Merit-based Incentive Payment System (MIPS), which is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), will raise the focus on physician performance measurement to a new level.

Robert A. Berenson, MD, a fellow at the Urban Institute in Washington, DC, recently authored an article in *JAMA* Forum critical of the legislation's focus on doctors' performance on what he calls a few, random, unreliable measures that he says give a misleading view of a physician's work.

A board-certified internist who practiced for 20 years before pursuing a health policy career, Berenson is one of the nation's best-known health policy experts. He has served on the Medicare Payment Advisory Commission, has headed up Medicare payment policy and private health plan contracting in the Centers for Medicare & Medicaid Services (CMS), and served as an assistant director of the White House Domestic Policy Staff under President Carter.

MIPS will replace the Physician Quality Reporting System (PQRS) and CMS will adjust Medicare payments to most physicians either up or down by as much as 9% depending on how well they score in four performance categories: quality, resource use, clinical practice improvement activities, and meaningful use of electronic health records systems. Also, physicians who score extremely high will be eligible for a 27% payment bonus.

In the interview below, Berenson elaborates on his views regarding MIPS.

Medical Economics:

Q: You've been critical of the measurement approach that CMS and other payers have adopted, and you focus in particular on MIPS. Are you concerned that MIPS will have some unintended consequences, and, if so, what concerns you most?

A: We lack measures that are core to what is central to the performance we expect from particular specialists. I also have concerns that the approach may compromise physicians' intrinsic motivation to practice high-quality care for their patients as they respond to specific incentives for particular aspects of performance.

With MIPS, Congress is combining PQRS, Meaningful Use and the value-based modifier. Those were three separate programs that were going to add up to a little more than 2% of a physician's Medicare payment. But the penalties under MIPS now add up to 9%, with potential gains of 27% for some lucky physicians. They've created a whole new formula for how you →34

→32 get either rewards or penalties. The new formula does provide room for rewarding quality improvement efforts, but that counts for only 15% of the total score. If we did a program that focused mostly on quality improvement, I would say, 'That's a good idea.'

But the MIPS program is like PQRS on steroids in that it puts so much at risk because doctors can lose as much as 9% of revenue automatically if they don't report anything when this program is totally phased in (by 2019).

Only about 50% of physicians in private practice today are submitting data for PQRS because of the administrative burden and the lack of respect practicing physicians have for what they are being measured on. But now, the total they stand to lose is only 2% or so. No one can afford to lose 9%, which means MIPS has the potential to hasten the demise of small practices.

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ROBERT A. BERENSON, MD

Q: Are you saying that physicians in small practices will get a bonus of 9% and have the potential to get a 27% bonus, but that's not enough of a financial gain to keep physicians in private practice?

A: The problem is that you as a physician would have to either spend money to bring in a consultant to produce the data from your medical records or you would have to use one of the registry options that CMS is offering. Both are resource intensive. Some doctors will say, 'I'm going to have to be part of somebody's system because I can't produce this data.'

That happened to my former practice. Shortly after I left they said, 'We can't administer this practice. It's getting too complicated. We're just going to sell to a hospital system.'

Q: By 'too complicated,' do you mean physicians don't have the sophisticated IT systems that they would need to collect and report the MIPS data? They don't have the staff to do it, and there are too many other demands on their time to do MIPS and still see 20 to 40 patients a day?

A: That's right. The obligations required to submit the data mean they will have to pay someone to do it for them. And we already know that small practices are just getting by and accept much lower payment levels from insurers than large practices do. To get back the 2% lost under PQRS, physicians could see a few more patients each week. But when [the loss is] 9% and the requirements are more complex, that's a whole different situation.

Included in the same MACRA legislation was a replacement for [Medicare] sustainable growth rate payments but that amounted to only nominal fee increases for the next decade. It's virtually nothing, meaning physician payment is not keeping pace with inflation and then you have the potential of losing 9% on top of that.

So, we're talking about the potential loss of payment above 9% and perhaps well into double digits. Look at it this way: because the fee increases aren't keeping up with inflation, practices will need some bonus income to stay even.

Q: So if it's no longer financially viable to operate a small physician practice, then is the only alternative to be acquired by a hospital, health system, or some larger entity, in particular because so many payers are moving to value-based care?

A: Yes. That's how it looks, and there are a lot of people in the insurer and provider worlds who say that the Affordable Care Act and now MACRA are all about bigness,

meaning consolidation. I don't believe that myself. But I believe the MACRA legislation indicates that physicians unwilling to accept the yet unproved value-based payment approaches will take a real hit, and when you combine that hit with all the other trends in the market, then you see all these factors pressuring small practices.

Now, if a small practice happens to be near a multispecialty group practice, they can seek to become an employee of that entity. That's not a bad alternative. Also, the independent practice association model is still thriving in some places, and I hope that the accountable care organization (ACO) model based in independent physician practices can be successful as well. It's a good sign for physicians that about half of all ACOs are physician-run organizations.

Q: To play devil's advocate, is it necessarily bad that many physicians will join larger organizations?

A: Well, in essence, we are under-valuing small practices and we now have MIPS which could be the death knell of many small practices. And for what? There's good evidence from a *Health Affairs* paper by Lawrence P. Casalino, MD, MPH, PhD, and others that, in fact, the smallest practices had the best performance on avoiding unnecessary hospital admissions. The researchers were surprised because they assumed that you needed systemic processes in place to keep ambulatory care-sensitive admissions down.

But what Casalino and others found is not surprising to me. Those doctors know their patients, and when something's wrong, they see them or they're on the phone with them. Then they solve the problem without admitting the patient or sending the patient to the ER, which often guarantees an admission. Conversely, many practices in large health systems don't know their patients as well. I am not saying small practices do as well on all aspects of care, just that what they do well is often underappreciated.

Q: You question whether we should even be using the performance measures we currently use. What are the proper measures to manage?

A: Recently, I coauthored a piece, "Beyond Measurement and Reward: Methods of Motivating Quality Improvement and Accountability" with Thomas Rice, PhD, in *Health Services Research* in which we said that CMS should promote collaborations between payers and providers to address topics with a potential for a high value outcome. CMS already has the model called the Partnership for Patients. It's been successful. Rather than just measuring and hoping it produces improvement, the approach involves active collaboration among providers and public and private payers to improve specific, important areas of deficient care, appealing to intrinsic motivation, not financial pay-off.

But at the individual doctor level, I believe—and behavioral economists have said so as well—that pay for performance (P4P) actually often is counter-productive. I'd like to know what impact P4P has before enacting a program like the MIPS. So far the evidence hasn't shown that the approach improves care. We need to evaluate not only what happens to the measures we incentivize, but what happens to overall care when health professionals are financially incentivized to improve particular aspects of care—the only ones we can measure. It may be that 'testing to the test' is the result.

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We have better and more valid measures for organizations than we do for measuring individual physician's performance. When we have public reporting of hospital readmissions, for example, we see that administrators and boards of directors get engaged and they adopt initiatives for the next few years to reduce readmission rates. That's what you want but what about all the other areas that aren't measured and get no attention?

Take, for example, the problem of diagnostic errors. I was on the committee that evaluated that issue for the Institute of Medicine. It would be great if we had measures for diagnostic accuracy, which is one

of the physician's most important skills. But today we have no way to measure whether Dr. Jones is a worse diagnostician than Dr. Smith, so the measure set that is part of MIPS is fundamentally deficient and likely misleading.

Or, consider hypertension. We do not even have a standard way of taking a blood pressure. There's a large amount of literature showing that many factors affect the BP reading, such as whether a patient is standing or sitting, whether you use the left arm or the right arm, the size of the cuff especially, and the conditions under which the blood pressure is taken. There's the well-known phenomenon of 'white coat hypertension.' But in performance measures we ask doctors to record a particular blood pressure reading, usually without the needed, evidence-based standardization.

If we're using blood pressure as a performance measure, we should do it correctly. Let's figure out the best way to do it, standardize that method, and then have all physicians do it the same way for three years.

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Reward improvement and guard against 'gaming.' Do a couple of important things well rather than measuring for its own sake. That way, we would at least get people's blood pressure under better control. That would be a good use of performance measurement.

We also talk about patient-centeredness, shared decision-making, and the quality of the doctor-patient relationship, and we're making some progress with patient experience measures, but that's still a work in progress.

Q: Can you explain why the quality of the patient-doctor relationship is important to patients?

A: Yes, and not many realize how important it is. From my perspective as a primary care physician, one big concern is how to manage patients who need referrals to a center of expertise or to a specialist of some kind. The needed provider may not be in the primary care doctor's network. We have no way to measure whether the physician in an ACO, for example, appropriately refers a patient to a comprehensive cancer center for a research protocol.

When does a patient need to go to a hand specialist as opposed to a general orthopedist for a hand injury? We should have evidence-based referral guidelines, but nobody's paying any attention to the referral issue because they assume performance measures will identify underservice. The measures aren't good enough or comprehensive enough for that.

Q: So, there's much work to be done. Is there any hope that Congress or CMS will even be willing to improve the MIPS program and perhaps take up some of these issues?

A: Well, MACRA, including MIPS, is the law now. Congress tells CMS to do it and CMS has to implement it. My prediction is we will see an annual review not unlike the SGR 'doc fix,' except this one will be easier to pass because there will be little budgetary impact. If there is enough pushback or unintended consequences, we may see a willingness to revisit the program. But that's uncertain now. ◘

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